Southern Cross Healthcare

Patient Admission Form

IMPORTANT: Please send this completed form to the hospital where you will have your procedure/surgery.

PERSONAL AND ADMINISTRATION DETAILS

Surname (family name): Thompson	Mr ☑ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐
First name(s): Michael	Preferred name: Mike
Date of birth: 05, 12, 1998	NHI: ZAA0067
Gender: ☑ Male ☐ Female ☐ I identify my gender as	
Residential address: 124 Mapleview Dr, Springfield, IL 62629	
Postal address: Same as above	
Email address: mrthompson12345@gmail.com	
Telephone: (Home) 555-361-1492 (Business) — (Mobile) —	
New Zealand resident: Yes ☐ No ☐ If No, complete the 'Acknowledgement Form: Non-NZ resident' (on our website).	
Which ethnic group do you belong to? Tick the box or boxes which apply to you. ☐ New Zealand European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☑ Other (such as Dutch, Japanese, Tokelauan) Please state: _____	
General Practitioner (Name): Daniel Park	Telephone: 555-246-8239
Medical Centre: Springfield Hospital	
NEXT OF KIN/CONTACT PERSON	
Name: Sarah Thompson	Relationship to patient: Spouse
Address: —	
Telephone: (Home) 555-246-1234 (Business) — (Mobile) —	

PAYMENT DETAILS

How will your procedure be paid for? Tick and complete as many as applies:

☐ Health insurance ☐ ACC ☐ DHB ☑ Paid personally ☐ Other .....

Details of health insurance ☐ Southern Cross Affiliated Provider contract

Name of Insurer: _____

Insurance Plan Name: _____ Membership No: _____

Have you obtained "prior approval" for payment? Yes ☐ No ☐ Approval No: _____

(Provide your prior approval letter in advance)

Additional charges

Depending on your health insurance policy or plan you may be required to pay an excess (co-payment).

You may also be required to pay for some charges such as visitor meals that are not covered by insurance, ACC or DHB.

Payment prior to surgery

You may be asked to pay a deposit 3–5 days before admission. The amount is based on the estimated cost of the procedure payable by you not otherwise covered by your insurance, ACC or DHB. The deposit will be refunded to you if the procedure is cancelled.

Methods of payment

We accept payment by EFTPOS, VISA, Mastercard, internet banking or online at our website

www.southerncrosshealthcare.co.nz (search “payment information”). Personal cheques are not accepted. We prefer not to receive payment by cash.

I will pay my account by: EFTPOS ☑ Credit Card ☐ Debit Card ☐ Internet Banking ☐

Internet banking details

Payee: Southern Cross Healthcare Ltd Bank a/c: 12-3113-0126623-00 Particulars: Patient Name Code: Date of Surgery e.g. 12 Sep 2020 Reference: Hospital e.g. Hamilton

Would you like to receive your invoice via email? ☑ YES ☐ NO

We will send the invoice to the email address you have provided above.

SCHL040 12/2020 Southern Cross Healthcare

Please complete the agreement section on the reverse of this page.

Kitty Wilde RN Case Manager

Vital Signs Flow Sheet

Patient: Michael Thompson	Notes: Patient presents left foot pain after ladder fall. Suspected metatarsal fracture.
DOB: 05/12/1978	
M/F: M	
Physician: Dr. Emily Carter	

Date	Weight	Temp.	BP	Pulse	Pulse OX	Pain	Initials
12/01/25	185	98.6	132/84	78	98	8	EC

www.Patient-Advocate.com

Kitty Wilde RN 805-452-3225

Foot X-ray